

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395478	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 10/31/2022
NAME OF PROVIDER OR SUPPLIER: PHILADELPHIA NURSING HOME STATE LICENSE NUMBER: 163902			STREET ADDRESS, CITY, STATE, ZIP CODE: GIRARD AND CORINTHIAN AVES PHILADELPHIA, PA 19130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 0000	<p>INITIAL COMMENT</p> <p>Based on the facility's notification of a closure, a closure survey was completed on October 31, 2022, at Philadelphia Nursing Home, it was determined that all residents had been relocated.</p>		P 0000		

(X6) DATE:



Certified End Page

PHILADELPHIA NURSING HOME

STATE LICENSE NUMBER: 163902

SURVEY EXIT DATE: 10/31/2022

**I Certify This Document to be a True and Correct Statement of Deficiencies and
Approved Facility Plan of Correction for the Above-Identified Facility Survey**

A handwritten signature in black ink that reads "Jeane Parisi".

Jeane Parisi
Deputy Secretary for Quality Assurance

A handwritten signature in black ink that reads "Debra L. Bogen MD".

Debra L. Bogen, MD, FAAP
Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY